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ABSTRACT

HIV/AIDS are affecting increasingly complex, more diverse populations, particularly communities of color. Despite National prevention efforts designed to speak to marginal experience, these communities continue to be disproportionately affected, especially in rural areas of the country which are difficult to access with communication about HIV. A study examined the communication strategies being used in minority-based public health HIV prevention efforts in Alabama, with a focus on rural communities with limited access to minority-run organizations. Interviews were conducted with HIV educators throughout the state, especially those engaged in rural outreach. Only one of 10 public health centers in Alabama is administered by African Americans, and, as a result, planning groups often come up with communication efforts that are unrealistic for actual HIV prevention for communities of color. Although health symposiums for health professionals occur, little actual outreach with at-risk communities is funded. However, some community-based organizations (CBOs) have had great success with minority populations. For example, one CBO set up tents, offered free food, soft drinks and prizes, and used a popular African American disc jockey from a local radio station to broadcast a live remote from the field next to a housing project where the events were held. Findings suggest that efforts to make communication in HIV prevention efforts must be made more culturally sensitive and relevant if they are to be effective in reaching marginalized communities. (Contains 17 references.) (NKA)

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In Search of a Voice: Rural HIV Prevention Campaigns

Designed for African Americans

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Running head: Search/Voice

Abstract

HIV/AIDS are affecting increasingly complex, diverse populations, particularly communities of color. Despite national prevention efforts designed to speak to marginal experience, these communities continue to be disproportionately affected, especially in rural areas of the country which are difficult to access with communication about HIV.

The purpose of this discussion is to examine the communication strategies being used in minority-based public health HIV prevention efforts in Alabama, with a focus on rural communities which have limited access to minority-run organizations. Toward that end, this paper reports findings of interviews conducted with HIV educators throughout the state, especially those engaged in rural outreach.

This research reveals that while efforts are being undertaken to make communication in HIV prevention efforts more culturally sensitive and relevant, whites remain in administrative positions within outreach organizations; the result is too often a continuation of a paternalistic, majority-driven approach to HIV prevention that has proven to be ineffective at reaching marginalized communities.

Search/Voice

HIV/AIDS are affecting increasingly complex and diverse communities, including teens and a broader range of marginalized groups. While behaviors, rather than groups, have become the focus of AIDS education since 1987, public health education must continue to speak to communities which are most heavily hit by the disease. Research has shown that such efforts, if they are to be successful, must make use of messages that are part of the experiences of people designed to hear them (Wiseman, 1989).

The purpose of this discussion is to examine the current state of public health communication about HIV/AIDS prevention directed toward marginalized populations, primarily African Americans, in rural areas of Alabama. The majority of research done on communication strategies used in HIV prevention has been conducted on urban, epi-center efforts where the disease first hit and where minority public health crises are heavily concentrated and evident. Far less research has been conducted on rural areas where the numbers of affected minorities are on the rise and where health care and affected populations are more dispersed. The South, and specifically Alabama, offers a particularly interesting area to explore regarding this issue because of its general history of race relations and the rural South's specific treatment of minorities in public health efforts - most notably with the Tuskegee syphilis experiments on blacks in Alabama.

LITERATURE

African Americans were first identified as being disproportionately affected by HIV/AIDS as early as 1987 (Stengel, 1987). In response, the government began a comprehensive minority-focused HIV prevention and communication program which contained

Search/Voice

several objectives. One was to involve more minority voices in HIV prevention efforts thus making outreach more culturally sensitive. Efforts have been made to include members of the affected communities in the planning, implementation, and evaluation of communication strategies used in minority outreach programs (Holman, et al., 1991): there has been an increased use of spokespeople, such as clergy, who are highly influential in African American communities; social networks, civic organizations, and family settings have been used to help disseminate information and open communication about HIV among community members (Bowles & Robinson, 1989).

Furthermore, persuasive message strategies and communication vehicles have been designed to take into account African American geographic locations, attitudes, beliefs, knowledge, and subjective norms in order to place HIV prevention in a culturally relevant and empowering context (Witte, 1992).

Communication research efforts into communities of color have also undergone changes. A shift has been made toward more culturally sensitive research which involves social anthropologists going into communities and using focus groups, opinion leaders, and outreach workers to determine educational approaches that would work best based on community members' assessments (Singer, 1992).

However, despite the above efforts, blacks continue to be disproportionately affected by HIV/AIDS. By 1990, while blacks accounted for 12 percent of the U.S. population, they also accounted for 28 percent of U.S. AIDS cases; more recent research shows that even this high percentage is probably a gross underestimate because of the underreporting of minority

Search/Voice

AIDS deaths (Lindan, et al., 1990, p. 400). These numbers indicate that efforts to communicate about HIV and limit its spread in black communities are less than successful ("Ill Treated," 1991).

Before looking at specific difficulties found in minority HIV outreach, it is important to get a sense of the general relationship between blacks and public health in this country. Because of discrimination on multiple levels, many African Americans have been extremely hard hit by poverty in the U.S. As a result, African Americans are also denied access to a multitude of social services including health care; for example, blacks have less access to health insurance, receive lower quality medical treatment, have more emergency room visits, and in general inhabit a position of alienation with regard to health care in the U.S.; one consequence of this situation is that blacks have higher rates of disease and shorter life spans than whites (Duh, 1991). Duh (1991) explains that this relationship to public health is the result of "discrimination in education and employment (which) has led to poverty which has led to poor health status, which has led to high rates of many disease including AIDS" (p. 113).

Historically, when the federal government has expressed interest in health care for and communication with minorities, research and outreach strategies have often further marginalized these groups. For example, in the Tuskegee, Alabama, Syphilis experiments, public health officials withheld medical treatments from blacks to determine the long-term effects of disease.

In less extreme cases, white public health care workers and policy makers tend to set

Search/Voice

agenda for minority populations which do not address the cultural context of minorities (Fernando, 1993). This has certainly been the case with HIV/AIDS outreach efforts. Too often the previously documented efforts at cultural sensitivity have been undertaken by white public health officials who have tended to transplant communication models created by white gays onto education efforts for blacks and Hispanics without substantive attention to cultural differences among and within minority populations, a proven necessity for effective outreach (Bayer, 1994; "Ill Treated," 1991; Patton, 1990).

When these approaches fail, educators often assume that target groups have not received the information, they are choosing to refuse to respond to messages opting instead to maintain unhealthy and dangerous lifestyles, and/or they continue to perceive AIDS/HIV as a gay white disease. Such assessments may in part be correct, but they also operate on at least two fallacious assumptions: once people have "accurate information" they can "correct" their behavior, and all people have equal access to power over their lives (Roth, 1993). Dalton (1989) claims that one of the major reasons HIV prevention is failing is because public health approaches by the majority-driven government are colonially structured, with whites positioned superiorly as disseminators of "true," accurate, value-free information to the less capable communities of color.

In fact, in many outreach programs, whites remain in top policy-making positions which control funding and designate organizational philosophy, while minorities tend to remain in immediate outreach positions - if anywhere at all (Fernando, 1993); furthermore, white public health officials tend to treat minorities as subordinates (Jenkins, 1992), people

Search/Voice

who are in need of help from white educators. Such situations mirror minority experience with majority culture, and communities of color again find themselves subordinated to white power and alienated from access to health care (Dalton, 1989).

It seems that what remains most daunting and threatening to HIV/AIDS policy-makers is the need for systemic changes in the distribution of resources and power in the struggle to combat the HIV/AIDS epidemic in communities of color. Singer (1994) argues that people must experience drastic improvements in quality of life in order to become capable of effectively responding to the AIDS/HIV threat. The obvious problem, however, is because public health - which is the primary, institutionally-recognized effort to control the disease - remains associated with and driven by dominant culture, it tends to maintain the current imbalance of power. While efforts are undertaken to make public health more culturally sensitive, the fact remains that in essential, philosophical ways, it remains an arm of what has historically been a racist government.

ALABAMA CASE STUDY

As mentioned earlier, Alabama is a particularly interesting area to examine communication strategies used in minority HIV prevention efforts because of its troubled history of race relations and public health, its rather remote geographic position within the U.S., and, most importantly, because of its disproportionately high infection rates among marginalized communities, especially African Americans. As of August, 1994, 2,865 Alabama residents were living with AIDS, and 3,758 had tested positive for HIV (Alabama Department of Public Health, 1995, p. 9). Public health educators throughout the state

Search/Voice

estimate the actual number of HIV-positive persons at 15,000. As of January, 1995, HIV/AIDS in African Americans were disproportionately high compared to other groups in the state: African Americans make up 26 % of the total population of Alabama, 48 % of the state's total AIDS cases, and 56 % of people reported as HIV positive (Alabama Department of Public Health, 1995, p. 18).

The ultimate goal of this study is to examine communication strategies used in rural, public health education designed to speak to and represent experiences of marginal identity as they exist in Alabama. To achieve this goal, onsite observations/interviews were conducted with HIV educators throughout the state; subjects included administrator/educators of all community-based HIV prevention and service organizations, representatives from the state health department, and educators from grassroots African American health organizations. Because of the particularly limited access of rural populations to minority-administered prevention, the results reported below will focus on strategies being used by educators dealing with primarily rural outreach. The success of programs is determined by the educators' self evaluation and the degree to which the communication strategies adhere to the criteria for effective outreach cited in HIV prevention literature.

The Context Of The State

Public health throughout Alabama has many obstacles to overcome in its outreach to and communication with African Americans. Historically and politically, the Tuskegee syphilis studies in Alabama, as mentioned above, enhanced a negative and adversarial relationship between African Americans and public health efforts, a relationship that continues

Search/Voice

to this day and a symptom of much racial tension that exists in Alabama where black and white cultures often remain fundamentally segregated. Too, state government has recently begun to rejuvenate explicitly racist symbolism, such as the use of chain gangs, and shown an unwillingness to support more equitable opportunities for minorities. Finally, Alabama is an economically-challenged state, and public health educators fear that the money it has budgeted for HIV prevention programs could be reduced by as much as 12 % by 1996.

For extremely rural communities in Alabama, several logistical problems also hamper communication and outreach efforts. For example, in sparsely populated areas, transportation is a problem for both the health educator and the person in need of direct service and education. Additionally, there are few organizational and group settings in which large numbers of people gather; as a result, groups of people are difficult to access with either printed educational materials or speaker presentations. Marginalized people in rural communities also experience great poverty, limited access to education, health care, and social services in general, and many mistrust government intervention.

There are also attitudes prevalent in rural communities in Alabama that adversely affect HIV/AIDS outreach programs. For instance, rural populations often view AIDS as something that is far removed from them in terms of geography and lifestyle; they see AIDS as a disease that primarily affects white gay men living in large cities. Highly religious, conservative, and homophobic beliefs also run rampant in these rural communities, and anything associated with AIDS tends to be perceived as immoral.

Finally, while there is much inequality for blacks throughout the state, segregation and

Search/Voice

the subordination of minorities in rural communities can be particularly extreme, resulting in black's mistrust of white-dominated public health efforts. This creates a significant problem in Alabama where all of the CBOs in rural areas are administered by whites, and in all but one case, boards are comprised of white majorities, in spite of the fact that half of all African Americans in the state who have been exposed to HIV/AIDS live in rural Alabama (State of Alabama Department of Public Health, 1995, p. 11).

State Department Of Public Health

The health department relies primarily on 10 statewide community-based organizations (CBOs) - only one of which is administered by African Americans - for its minority-based outreach. CBOs are non-profit organizations supported by governmental funds and private donations whose purpose is to provide education, service, and advocacy for communities affected by and infected with HIV/AIDS. Alabama's health department turns over specific concerns of minority outreach, especially in rural areas, to CBOs because they have geographic access to minority communities.

Such a strategy has complex consequences. On one hand, people working for the CBOs are not directly associated with the state health department and, in theory, speak from more credible positions; however, power for minority outreach remains in the hands of predominately white-run organizations. Moreover, the health department appears to occupy a somewhat passive, facilitative position with respect to minority outreach and fails to offer a proactive, aggressive response to the disproportionately high minority infection rates in the state. While the health department is aware of, and can cite, effective programs in place in

Search/Voice

CBO efforts, there is no clear, sustained, or strategic attempt to use successful programs to strengthen overall minority prevention. In general, the health department's response to HIV/AIDS seems to be heavily bureaucratic, largely reactive, and educationally and philosophically generic.

One of the areas the health department is focusing much of its efforts for minority HIV outreach and communication is in a Centers for Disease Control -(CDC)- mandated program called community planning. In this program, the health department establishes planning teams in various geographic areas throughout the state; these teams - comprised of health educators and local leaders ideally from specific at-risk communities - meet and determine ways to assess the HIV prevention needs of minority populations in their areas and then establish culturally sensitive programs which will respond to the identified needs. On the surface, community planning appears to be a culturally sensitive and empowering strategy for including minority voices in HIV communication efforts, especially for rural areas which typically have less immediate access to government-funding and minority-administered HIV prevention organizations. The state maintains that its community planning teams are quite inclusive of minorities as all groups are reported to have from 28 % to 55 % African American membership (Alabama Department of Health, 1995, p. 5).

However, these percentages do not always reflect the number of African Americans who are actually involved throughout the planning process. Actual participation in the state's community planning effort is affected by several factors: logistical difficulties in soliciting and sustaining minority membership for the planning teams because of time and transportation

Search/Voice

barriers; historical issues which make minority populations suspicious of forging a relationship with a governmentally-endorsed program; and a philosophical reluctance on the part of some educators to acknowledge the impact of Alabama's historical marginalization of African Americans on current communication and HIV prevention.

Several of the state's public educators also question exactly who is being empowered by community planning. For example, one CBO director claimed that the planning program has great potential, and, in theory, certainly seems to encourage minority participation in HIV prevention programs. In fact, the director believes that the planning groups are quite successful at identifying community needs. The problem is that there is no mechanism to ensure that qualified people have some degree of control over how those needs can be met with effective HIV prevention programs.

As a result, the planning groups often come up with communication efforts that are either unrealistic or tend to proliferate bureaucracy rather than participate in actual HIV prevention for communities of color. For example, one group is using its outreach resources to sponsor a one-day symposium for health professionals that will focus on minority-based education, but there is no actual outreach being funded by this program. One educator points out that it is much easier to meet in a convention center with other professionals than it is to spend the weekend directly talking with at-risk communities.

The result is that the CDC and the state health department are using ineffective programs to enhance minority outreach; paradoxically, it appears that minority populations are at fault for not devising more effective prevention programs for their own communities.

Search/Voice

Community-Based Organizations

The following discussion will focus on organizations which represent successes and problems typical of rural CBOs in Alabama. Despite problems with governmental bureaucracy, rural CBOs throughout the state have accomplished some amazing feats with regard to minority outreach, and all have made significant inroads into marginalized populations. However, many of the educators remain largely unsatisfied with the degree of minority involvement they have been able to achieve.

For example, one CBO successfully produced community events which included HIV prevention education and testing for minority populations. The director, using data on recent HIV infection rates, first identified disenfranchised African American females as a key target population and then located the educational site in housing projects where minority women were victims of extreme poverty, drug use, and sexual abuse.

To access this group, the director personally contacted a community center coordinator who worked with the housing projects. He helped organize and advertise the effort which was held in an adjacent athletic field. For the event, the CBO set up tents, offered free food, soft drinks and prizes, and used a popular African American disc jockey from a local radio station to broadcast a live remote from the field; tents were used to display and distribute educational literature and videos (one produced by local black teens) and as an HIV testing site. The CBO director deemed the outreach a success based on the number of people tested, the significant turnout for the event, and the positive community relations facilitated between the CBO and minority populations. The organization created a non-threatening environment for

Search/Voice

communication about HIV that was entertaining, educational, and made use of positive peer influence.

Such an event demonstrates the capability of educators in rural areas to reach into communities not represented by the sponsoring, predominately white, public health organization. One reason such an effort was a success is because the CBO remained sensitive to the issues regarding minority HIV communication and outreach cited in the literature above: the CBO proactively approached and physically entered the community, located the educational event within that community - not at the site of the white-based CBO or county health department, solicited the active aid and support of African American leaders and peers in the planning and implementation of the outreach, made use of motivational strategies that encouraged people to attend, and included local personalities for positive peer influence. All of these strategies use the HIV prevention effort to create communication and relations between the white-based CBO and minority populations.

However, the CBO has been unable to enact long term, systemic changes that would make the organization more inclusive of African American participation. For example, according to the director, minorities remain hesitant to access the organization's facility because of a general mistrust of white-dominated public health efforts and the fear of being associated with the highly stigmatized disease. The CBO has also encountered great difficulty recruiting minorities for administration positions within the organization, and the board, staff, and community planning members remain predominately white; of course, this hinders efforts to design and implement HIV prevention which will speak relevantly to communities of color.

Search/Voice

For example, at a recent community planning meeting, only three of 20 participants were African Americans; as a result, whites essentially identified issues that they thought needed to be addressed by black populations. Furthermore, the planning group encountered problems implementing its minority outreach effort. The committee decided to approach local factories which employed large populations of African American women - the designated target group - with speakers and literature. However, the businesses were contacted through correspondence rather than personally and remained largely unresponsive; additionally, there was a lack of consideration on the part of the community planners about whether or not the employers would allow the workers to take time during the work day to hear presentations. The planning group also wanted to begin a mentoring program in African American communities through local black churches, but religious leaders have been resistant to participation which the CBO interprets as the church's attempt to distance itself from HIV/AIDS by turning responsibility for prevention over to public health organizations.

These obstacles reflect central areas of concern with minority-based outreach which is administered by white-dominated organizations. First, actual African American involvement in the community planning group suggests that the state's figures regarding minority participation are not always reflective of the actual makeup of the groups for reasons discussed above. Second, white outreach workers have difficulty creating and maintaining contacts with black communities, especially when efforts are made through correspondence rather than personal contact. Even more of a barrier is the educator's distance from the daily experience of the at-risk communities s/he is trying to reach. The white administrators, outreach workers,

Search/Voice

and community planning members have much more cultural power than their black audiences and, consequently, remain unable to consider substantive reasons outreach strategies might be blocked because of occupational, personal, and/or social realities the at-risk communities face daily. Furthermore, when approaching African American civic organizations such as the black church for support, HIV prevention must be made relevant to a multiplicity of concerns with which blacks are confronted; the CBO must go beyond merely requesting help with HIV prevention and place HIV/AIDS in the context of affected communities that face discrimination, poverty, and limited access to employment, education, and health care in general.

This rural CBO is clearly making substantive efforts to reach out to and communicate with minority communities at-risk, but problems caused by an unequal distribution of power and cultural differences between the white-run organization and disenfranchised, black audiences confound success rates. The ultimate consequence is that, in spite of efforts to the contrary, the CBO often maintains a traditional, liberal approach to public health which positions whites as disseminators of value-free, "truthful" information to uninformed, subordinate minority populations. While this is certainly not the intent of the CBO's efforts, it is a result of white-administered and dominated HIV prevention efforts aimed at African Americans. Such a consequence, as documented in the previously discussed literature, mirrors marginalizing experiences African Americans face in the culture at large and renders public health more paternalistic than empowering. This situation is particularly dangerous in rural areas of the state where African Americans have no access to minority-run organizations.

Search/Voice

Another CBO, though situated in a small city, does much outreach to rural, migrant Hispanic communities as well as to inner city communities of color. Interestingly, while the CBO is administered by whites, minorities - from the county health department and the CBO's volunteer pool - actively participate in the planning, implementation, and evaluation of the area's HIV prevention efforts. Though these efforts are not always successful, they do represent a much needed shift of power in Alabama's public health education system.

The county health department representative, who is in charge of the area's community planning effort and outreach to African Americans, provides a confirmation of the earlier documented reasons why communities of color in Alabama remain alienated by public health: many African Americans in the area are victims of extreme poverty which limits access to an array of basic health and human services; attitudes also prevail that associate HIV with white gay men living in large cities and government-sponsored, public health efforts with the Tuskegee experiments.

The primary strategy the county health department is using to overcome these obstacles to communication and enlist minority participation in education is peer teen counseling in which at-risk youth talk to others about HIV in an attempt to deal with misconceptions about the disease. However, there does not appear to be a comprehensive, strategic, minority-based program in place that responds to, and has as its origin, the total experience of communities of color. Additionally, the educator is seeking support for peer-based prevention from community leaders who work with at-risk groups in housing projects, churches, and civic organizations. Notwithstanding, her efforts have been largely limited to correspondence in

Search/Voice

which she solicited assistance for a program that has essentially been pre-designed by the health department.

In ways, the idea here is a good one: a member of the at-risk communities being approached is in charge of outreach to those groups; the outreach coordinator is clearly sensitive to the cultural experience of the black populations she is targeting and aware of the obstacles her outreach must overcome; and she recognizes the importance of enlisting support for and responsibility of education from the community itself. The problem is that the educator has remained too philosophically close to the health department in the scope and design of her outreach and too physically distanced from her target populations. As a result, the health department worker has been unable to place HIV in a relevant context for disenfranchised African Americans and involve them substantively in the planning, implementation, and evaluation of HIV communication efforts. Consequently, her solicitations have remained largely unanswered and the outreach unrealized.

On the other hand, there is a CBO volunteer who has been performing outreach to migrant Hispanic communities in rural areas surrounding the city who has approached outreach in a radically different way and to a much more successful effect. The area's Hispanic/latino communities have much in common with many marginalized groups: they face discrimination and extreme poverty, limited access to basic health and human services, and fear/mistrust of government-based public health intervention. These migrant workers are often afraid that the government is trying to identify them as illegal aliens and incarcerate them or deport them back to their homelands. Additionally, the volunteer educator identifies cultural beliefs of

Search/Voice

machismo that cause much stigma about AIDS and its association with gays which prevents Hispanics from accurately assessing risk. Because of the predominance of Catholicism in Hispanic communities, there is also a religious-based resistance to condom use. Finally, the largely transitory nature of this population makes it extremely difficult to maintain continuous and coherent education and communication.

In response, the volunteer worker - who is also Hispanic and speaks the language of the communities - has directly entered this population in multiple ways. First, aware of the importance of family and the fear and mistrust of white-based, governmental intervention for this community, she has physically gone door to door, entered people's homes, and talked with them about their personal, familial, and social needs; she then discusses the role of HIV prevention in the context of these cultural realities. The volunteer educator realizes that marginalized populations often have more immediate and basic survival needs - such as money, employment, transportation, education - than HIV prevention, and communication efforts must remain responsive to and value these priorities. Consequently, the educator, in her outreach, also accesses a variety of health and human service offerings that are available to disenfranchised populations, services that respond to realities of poverty and provide assistance for employment, education, and health care needs.

The volunteer educator also employs an effective strategy for enlisting the aid of community leaders. She makes personal contacts with gatekeepers from schools, boys/girls clubs, area churches, and community centers and talks with them about the need for their support in HIV prevention education for their communities. She provides the community

Search/Voice

leaders with ideas for culturally relevant outreach, encourages them to contact her when they are ready to put such an event together, and then facilitates its production. She continues to contact the community leaders until they respond.

The volunteer's communication strategies are examples of substantive and effective efforts made by members of at-risk communities to reach into marginal populations, remain sensitive to the needs and cultural realities of those communities, and enable community members' control of and responsibility for HIV prevention efforts. This is also an example of HIV prevention outreach that, in the design and scope of communication strategies, deals with the comprehensive experience of people within the at-risk populations; HIV prevention is placed in the larger context of the overall health and human service needs of the target audiences being addressed.

Currently, the health department representative and the volunteer educator are working together through the CBO. The volunteer has been providing names of contact people, marginal outreach strategies, and funding bureaucracies which can be used to make the area's African American outreach more effective. This relationship is being facilitated by the white-administered CBO which remains problematic. However, the CBO is also the conduit by which institutional and marginal voices are coming together to plan, implement, and evaluate HIV prevention programs for communities of color. In a sense, the CBO places authority for HIV prevention in the hands of minorities who set agenda for the organization's minority outreach. Given the white-based control of all rural CBO's in the state, this organization's approach is particularly important because it substantively places minorities in positions of

Search/Voice

authority with regard to public health and marks a shift in the balance of power.

Finally, the rural CBOs in Alabama that appear to be offering minimal outreach to minority communities are doing so primarily because they either lack resources for or a philosophical understanding of minority outreach. For example, one organization which had recently undergone major organizational changes was actually attempting several of the recommended strategies cited above. She had contacted at least two community leaders from housing projects which happened to contain large African American populations, and she was preparing to personally enter these communities with the leaders and instigate HIV prevention outreach. The problem is that the CBO director is not a member of the at-risk communities and will, consequently, be perceived as an outsider.

Even more of a concern is that the outreach worker philosophically remains unaware of the importance of sending in members of minority communities to perform the outreach without her; she fails to realize that, as a government-sponsored member of the white majority, she is a liability for outreach to disenfranchised African American populations. This oversight in the assessment of the needs and realities of the communities at-risk will severely limit the effectiveness of outreach to the targeted groups.

In summary, successful HIV prevention outreach in rural Alabama is a product of direct, personal contact with marginal communities, education that is sensitive to the individual, cultural, and linguistic identities of at-risk populations, enlistment of these populations in the planning, implementation, and evaluation of HIV prevention efforts, and an awareness of the context in which people live. Effective HIV prevention has its starting point

Search/Voice

in the communities themselves; the outreach that fails to reach marginal populations has in some way been unable to locate itself within marginal experiences.

CONCLUSION

The above discussion attempts - especially in light of the growing and disproportionate numbers of HIV infection rates among minorities in Alabama - to point out that community-based education in the second decade of the epidemic in a primarily rural state with a troubled racial history is in need of some dramatic shifts in the distribution of power with regard to public health.

The state-wide rural efforts and organizations serving people affected and infected by HIV/AIDS need to look more like the populations they are attempting to reach, and this change in appearance needs to occur throughout public health organizations, especially in administrative positions. In making such a radical change, there will also hopefully be a shift in the ability of HIV prevention programs to address the realities of at-risk communities' lived experiences. Without a deeper understanding of the cultures of minority populations, public health will continue to function as a paternalistic effort that maintains power for dominant culture and the marginal position of communities of color.

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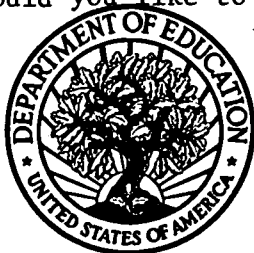
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Search/Voice

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